

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

13671

13639

MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Springfield State Hospital</i>		d. STREET ADDRESS <i>9211 FLEWER AVE 15222</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>HATTIE ANNA BENNINGHOVEN</i>		4. DATE OF DEATH <i>Dec. - 10 - 1960</i>	
5. SEX <i>Fem.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-1-1876</i>
9. AGE (In years last birthday) <i>84</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Casper Schmidt</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Hendrick</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Springfield Hosp. Records</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal Broncho-Pneumonia</i> 422-1 DUE TO (b) <i>Arteriosclerotic Cardio Vascular Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <i>Generalized Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Menige Brain Syndrome assoc. with Cerebral arteriosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (if (this hospital) attended the deceased from <i>9-14-1959</i> to <i>12-10-1960</i> , that (if (we) last saw the deceased alive on <i>12-10-1960</i> , and that death occurred at <i>12-10-1960</i> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <i>Konstantin Weber M.D.</i>		22b. DATE SIGNED <i>12-10-1960</i>	
22c. PHYSICIAN'S NAME (Type) <i>Konstantin W E B E R M.D.</i>		22d. ADDRESS <i>Oak Street Sykesville, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/13/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>Arlington, Virginia</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H.Hines Co.-2901 14th St., N.W.</i>		25a. REC'D BY REGISTRAR <i>DEC 13 '60</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>		DATE <i>DEC 13 '60</i>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

13672

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13640

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN lb 3yr.9mo.21da.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 11 d. STREET ADDRESS 3149 Keswick Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Howard Last Bigham		4. DATE OF DEATH Month December Day 6 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 20, 1888
9. AGE (In years last birthday) 72		10. IF UNDER 1 YEAR Months 72 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill hand		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Bigham		14. MOTHER'S MAIDEN NAME Sara Yealing	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 215-07-6727	
17. INFORMANT Springfield State Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Generalized arteriosclerosis DUE TO (c) C.B.S. assoc. with senile brain disease with psychotic reaction. Bronchopneumonia. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) C.B.S. assoc. with senile brain disease with psychotic reaction. Bronchopneumonia. INTERVAL BETWEEN ONSET AND DEATH years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 10:10 A.M.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from February 15, 1957 , that (I) (we) last saw the deceased alive on December 6, 1960 , and that death occurred at 10:10 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo 22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22b. DATE SIGNED 12-6-60 22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/9-60	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemty.		23d. LOCATION (City, town, or county) (State) Baltimore City. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Seitz		25a. REC'D BY REGISTRAR DATE DEC 8 '60 25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

1950

STATE OF TEXAS
DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

1950

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		10-15-1905		Dallas, Texas	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Teacher		High School		Methodist	
Date of Death		Time of Death		Place of Death		Physician		Hospital	
10-20-1950		10:30 AM		Dallas, Texas		Dr. J. Smith		St. Mary's	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Death Certifier	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

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VR A15 (4)
15M 9/59

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13673
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13641

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ o. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3mos. 9days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nicola Middle Biscotti Last Biscotti		4. DATE OF DEATH Month December Day 29 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 23 1880
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 80 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Naturalized	
13. FATHER'S NAME Peter Biscotti		14. MOTHER'S MAIDEN NAME Anne Ecrolino	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-32-9145	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease. DUE TO 420.00 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis. DUE TO (c) Bronchopneumonia.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circ. dist. with cerebral arteriosclerosis, with psychotic reaction. - Old and recent infarcts and subdural hematoma rt.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) side of brain.	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/20/1960 to 12/29/1960 , that (I) (we) last saw the deceased alive on 12/29/60 , and that death occurred at 10:20 AM the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo		22b. DATE 12/29/60	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 5 1961	
23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION (City, town, or county) (State) 4430 Belair Rd Balto. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE FRANK DELLA NOCE		25a. REC'D BY REGISTRAR 3 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hume			

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 08-10-2010 BY 60322 UCBAW/SJS

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VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARTHA ELIZABETH BLOOM					4. DATE OF DEATH Month Dec. Day 12 Year 1960				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-3-1878		9. AGE (In years last birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Judson Boswell					14. MOTHER'S MAIDEN NAME Martha Severn				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Mrs. Ruth Unglesbee, Sykesville, Md Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure, arteriosclerosis generalized 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Mial nutrition, chronic brain DUE TO (c) Syndrome								INTERVAL BETWEEN ONSET AND DEATH Nov 60 to 12 Dec 60	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Nov 60 19 60 , to 12 Dec 19 60 , that (I) (we) last saw the deceased alive on 12 Dec 19 60 , and that death occurred at 12 PM , from the causes and on the date stated above.									
22a. SIGNATURE Howard E. Hall					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) HOWARD E HALL					22d. ADDRESS Sykesville, Md 13 Dec 60				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12-15-60		23c. NAME OF CEMETERY OR CREMATORY Methodist			23d. LOCATION (City, town, or county) (State) Poplar Springs Md	
24. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md					25a. REC'D BY REGISTRAR DATE DEC 19 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13675 CERTIFICATE OF DEATH

Reg. Dist. No. 13643

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>CARROLL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <u>UNION BRIDGE, MD.</u>		<u>4 yr</u>		TOWN <u>UNION BRIDGE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>SAMUEL</u> (Middle) <u>VERNON</u> (Last) <u>BUTLER</u>				(Month) <u>12</u> (Day) <u>5</u> (Year) <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>B</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>1892</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LONG SHAMAN</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MD</u>	12. CITIZEN OF WHAT COUNTRY? <u>Frederick Co</u>		
13. FATHER'S NAME <u>SAMUEL BUTLER</u>				14. MOTHER'S MAIDEN NAME <u>ANNA MARIE BOWIE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WAR 1</u>				16. SOCIAL SECURITY NO. <u>215-03-9881</u>		17. INFORMANT & ADDRESS <u>CARRIE BUTLER Union Bridge, Md</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
5705 IMMEDIATE CAUSE (A) <u>Intestinal Obstruction</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u></u>							
DUE TO (C) <u></u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 4</u> , 19 <u>60</u> , to <u>Dec 5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Dec 4</u> , 19 <u>60</u> , and that death occurred at <u>Dec 5</u> , 19 <u>60</u> , M, from the causes and on the date stated above.							
SIGNATURE <u>J. N. Legg</u>				ADDRESS (Street, city, town, state) <u>Union Bridge Md</u>		DATE SIGNED <u>12-5-60</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Dec 7-60</u>		NAME OF CEMETERY OR CREMATORY <u>Libertytown</u>		LOCATION (City, town, or county) (State) <u>Libertytown Md</u>	
24. REC'D BY REGISTRAR <u>DEC 9 '60</u>		REGISTRAR'S SIGNATURE <u>Arthur L. King</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>RAYMOND K. WRIGHT</u>		ADDRESS <u>Union Bridge Md</u>	

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VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13676

13644

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson #4 FORMERLY - 2102 BOONE ST. BALTO. 18</u>	
c. LENGTH OF STAY IN 1b <u>2 mo. - 12 days</u>		d. STREET ADDRESS <u>Presbyterian Home of Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary Ann</u> Middle <u>Heymes</u> Last <u>CHALK</u>		4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-23-79</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Heymes, dec.</u>		14. MOTHER'S MAIDEN NAME <u>Rebecka Rudd, dec.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Springfield State Hospital, Sykesville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral pneumonia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CBS assoc. with cerebral arteriosclerosis.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-14</u> <u>1960</u> , to <u>12-25</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>4:25 p.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Agustin del Campo.</u>		22b. DATE SIGNED <u>12-26-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Agustin del Campo, M.D.</u>		22d. ADDRESS <u>Sykesville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-29-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE PARK</u>		23d. LOCATION (City, town, or county) (State) <u>WOODLAWN, M.D.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN O. MITCHELL & SONS, INC.</u>		25a. REC'D BY REGISTRAR <u>DEC 28 '60</u>	
ADDRESS <u>1900 EUTAW PLACE</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

18678

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH
STATE OF NEW YORK

18678

Blank form with horizontal lines for text entry.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

13677

MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13645

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. LENGTH OF STAY IN 1b 3 m. 25 d.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Amelia Middle Alberta Last Christy		4. DATE OF DEATH Month 12 Day 14 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/14/70
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cornelius Frostle		14. MOTHER'S MAIDEN NAME Kensler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Springfield Hospital records, Sykesville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary sclerosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Arteriosclerotic cardio-vascular disease DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH month years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
Chronic brain syndrome associated with senile brain disease with psychotic reaction.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/19/1960 to 12/14/1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/14/1960 , and that death occurred at 9:00 PM , from the causes and on the date stated above.			
22a. SIGNATURE Rita S. Glahn		22b. DATE SIGNED 12/15/60	
22c. PHYSICIAN'S NAME (Type) Rita S. Glahn, M. D.		22d. ADDRESS Springfield State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec.17/60	
23c. NAME OF CEMETERY OR CREMATORY Western		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D.4101		25a. REC'D BY REGISTRAR DEC 19 '60	
25b. REGISTRAR'S SIGNATURE Edmondson Ave.			

1904

CERTIFICATE OF DEATH

1904

DEPARTMENT OF HEALTH
STATE OF NEW YORK

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of death: _____
5. Place of death: _____
6. Cause of death: _____
7. Signature of physician: _____
8. Signature of registrar: _____
9. Signature of witness: _____
10. Signature of coroner: _____
11. Signature of justice: _____
12. Signature of clerk: _____
13. Signature of health officer: _____
14. Signature of superintendent: _____
15. Signature of commissioner: _____
16. Signature of governor: _____
17. Signature of president: _____
18. Signature of vice president: _____
19. Signature of secretary: _____
20. Signature of treasurer: _____
21. Signature of auditor: _____
22. Signature of controller: _____
23. Signature of comptroller: _____
24. Signature of attorney general: _____
25. Signature of state senator: _____
26. Signature of state assemblyman: _____
27. Signature of state representative: _____
28. Signature of state legislator: _____
29. Signature of state official: _____
30. Signature of state employee: _____
31. Signature of state agent: _____
32. Signature of state clerk: _____
33. Signature of state messenger: _____
34. Signature of state janitor: _____
35. Signature of state cook: _____
36. Signature of state steward: _____
37. Signature of state waiter: _____
38. Signature of state porter: _____
39. Signature of state driver: _____
40. Signature of state messenger: _____
41. Signature of state clerk: _____
42. Signature of state messenger: _____
43. Signature of state clerk: _____
44. Signature of state messenger: _____
45. Signature of state clerk: _____
46. Signature of state messenger: _____
47. Signature of state clerk: _____
48. Signature of state messenger: _____
49. Signature of state clerk: _____
50. Signature of state messenger: _____

13665

CERTIFICATE OF DEATH

Reg. Dist. No.

13646

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Carroll</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i>				c. LENGTH OF STAY IN 1b <i>10 yrs</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>111 S. Main</i>				e. STREET ADDRESS <i>111 S. Main</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>JAMES</i> Middle <i>VERYL</i> Last <i>CRAMER</i>				4. DATE OF DEATH Month <i>Dec.</i> Day <i>8</i> Year <i>1960</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 4-1906</i>	9. AGE (In years last birthday) <i>54</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Accountant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Accounting</i>		11. BIRTHPLACE (State or foreign country) <i>Dumore, Pa</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Oscar Cramer</i>				14. MOTHER'S MAIDEN NAME <i>Cora Wise</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-03-654</i>		17. INFORMANT <i>Wm J. Cheryl Cramer</i> Address <i>Manchester, Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive pneumonia</i> <i>430.9</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Congestive Heart Failure</i> DUE TO (c) <i>Sub Acute Bacterial Endocarditis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 mth</i> <i>1 Month</i> <i>5 Month</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hemiplegia not secondary to Endocarditis</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <i>Dec</i> , 1950, to <i>Dec 8</i> , 1960, that I last saw the deceased alive on <i>Dec 7</i> , 1960, and that death occurred at <i>2:00 P</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Manchester Md</i> DATE SIGNED <i>12-8-60</i>							
ACTUAL SIGNATURE <i>W H Foward</i>		M.D. <i>Manchester Md</i>					
PHYSICIAN'S NAME (Type) <i>W H Foward M.D.</i>		<i>Manchester, Md</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/10/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Fineboro Md</i>	22d. LOCATION (City, town, or county)	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. K. Kiehl</i>			ADDRESS <i>Elba Rock, Pa.</i>	24a. REC'D BY REGISTRAR DATE <i>DEC 12 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>		

TO HOSPITAL: ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1940

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968	
AGE		DATE OF BIRTH	
35		APRIL 10, 1933	
SEX		PLACE OF BIRTH	
MALE		MEMPHIS, TENNESSEE	
RACE		OCCUPATION	
WHITE		ATTORNEY	
MARRIAGE		EDUCATION	
MARRIED		HIGH SCHOOL	
RELIGION		CAUSE OF DEATH	
METHODIST		HEART DISEASE	
PREVIOUS ILLNESS		MANNER OF DEATH	
NONE		NATURAL	
PLACE OF DEATH		CITY	
BALTIMORE		STATE	
COUNTY		COUNTRY	
BALTIMORE		UNITED STATES OF AMERICA	
SIGNATURE OF DECEASED		SIGNATURE OF PHYSICIAN	
[Signature]		[Signature]	
DATE		DATE	
APRIL 4, 1968		APRIL 4, 1968	

1. This certificate is to be filled out by the physician who attended the deceased or by the medical examiner or by the coroner. It is to be filled out in the case of a death which is reported to the health department. It is to be filled out in the case of a death which is reported to the health department. It is to be filled out in the case of a death which is reported to the health department.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13678

CERTIFICATE OF DEATH

Reg. Dist. No.

13647

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Nr. Westminster		c. LENGTH OF STAY IN 1b 75 Years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Nr. Westminster		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westminster, Md. R. D. 1	
d. STREET ADDRESS Westminster, Md. R. D. 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle --- Last Crouse		4. DATE OF DEATH Month December Day 11 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1860
9. AGE (In years last birthday) 100 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-Housework, Retired, Own home.	
11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph L. Sharrer		14. MOTHER'S MAIDEN NAME Matilda Sholl	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Airy Bish, Westminster, Md. R. D. 1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Liver 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH about 2 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Serility		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Dec 15 , 19 50 , to 12-11 , 19 60 , that I last saw the deceased alive on 12-10 , 19 60 , and that death occurred at 9 a. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE C. L. Billingslea M.D.		ADDRESS (Street, city or town, state) Westminster, Md.	
DATE SIGNED 12-12-60			
PHYSICIAN'S NAME (Type) C. L. Billingslea M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/14/60	
22c. NAME OF CEMETERY OR CREMATORY Kriders Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Westminster, Carroll Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little		ADDRESS Littlestown, Pa.	
24a. REC'D BY REGISTRAR DEC 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
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13679

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13648

1. PLACE OF DEATH o. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>3X01-4</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. LENGTH OF STAY IN H. <i>13 mos 22 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Springfield State Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. NAME OF DECEASED (Type or print) <i>JDA</i> First <i>MAY</i> Middle <i>CUNNINGHAM</i> Last		4. DATE OF DEATH <i>12 - 31 - 1960</i> Month Day Year	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-7-76</i>
9. AGE (In years lost birthday) <i>84</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bookkeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Office</i>	
11. BIRTHPLACE (State or foreign country) <i>U. S. A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>FRANK Cunningham</i>		14. MOTHER'S MAIDEN NAME <i>Mary Jane Cargill</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>215-507-9823</i>	
17. INFORMANT <i>Hospital Records</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Coronary Sclerosis</i> 420.0 DUE TO <i>Sclerotic Heart Disease</i> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. DUE TO <i>Generalized Arteriosclerosis</i> (c) <i>Generalized Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>years</i> <i>years</i> <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Chronic Brain Syndrome assoc. with Cerebral Arteriosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <i>He</i> (this hospital) attended the deceased from <i>8-11-59</i> to <i>12-31-60</i> , that <i>He</i> (we) last saw the deceased alive on <i>12-31-1960</i> , and that death occurred at <i>5:20 P. M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Konstantin Weber</i> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Konstantin WEBER M.D.</i>		22d. ADDRESS <i>Oak Street, Sykesville, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Jan 3-1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge</i>		23d. LOCATION (City, town, or county) (State) <i>Pikesville, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Burgess Funeral Home</i> ADDRESS <i>3631 Fall Road</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 3 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>William S. Thomas</i>			

2-28

CERTIFICATE OF DEATH

1887



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

13680

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13649

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Cumberland Rt. # 2					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS DeHaven Road					
3. NAME OF DECEASED (Type or print) First Amos Middle Gugurtha Last DeHaven				4. DATE OF DEATH Month December Day 6 Year 1960					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 20, 1878			
9. AGE (In years lost birthday) 82 yrs.		IF UNDER 1 YEAR Months 0 Days 1 Hours 2 Min.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)				10b. KIND OF BUSINESS OR INDUSTRY Farm owner					
13. FATHER'S NAME Galusha DeHaven				14. MOTHER'S MAIDEN NAME Virginia Lamp					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield State Hospital Records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene of the ascending colon secondary to 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) / Thrombosis of the inferior mesenteric artery DUE TO (c) Arteriosclerosis of the descending aorta								INTERVAL BETWEEN ONSET AND DEATH 3 hours 3 hours years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with disturbance of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction.								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Springfield State Hospital				20g. (County) Sykesville		20h. (State) Maryland			
21. I certify that (I) (this hospital) attended the deceased from September 30, 1960 to December 6, 1960 , that (I) (we) last saw the deceased alive on December 5, 1960 , and that death occurred at 5:50 A.M. from the causes and on the date stated above.									
22a. SIGNATURE Agustin del Campo				22b. DATE SIGNED 12-6-60					
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				22d. ADDRESS Springfield State Hospital Sykesville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/9/60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DEC 12 '60			
				25b. REGISTRAR'S SIGNATURE Charles L. George					

15880

STATE OF OHIO

15880

[The remainder of the page contains extremely faint, illegible text, likely bleed-through from the reverse side of the document.]

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13650

13681

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4 yr. 5mo. 2da.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Glen Burnie, Md. b. COUNTY Anne Arundel Co.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		d. STREET ADDRESS 2 S. Broadview Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Willie Alverta Dennis		4. DATE OF DEATH Month Day Year Dec. 26, 1960		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-30-94		9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME George William Dennis		14. MOTHER'S MAIDEN NAME Alice Dwyer		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. N o									
17. INFORMANT Hospital Records		Address Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 491x DUE TO (c) 50 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CB S associated with Convulsive disorder without qualifying phrase		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6-28 19 56 to 12-26 19 60 that (I) (we) last saw the deceased alive on Dec. 26 19 60 , and that death occurred on 11:30 P.M. from the causes and on the date stated above.		22a. SIGNATURE Dr. Ilse Kamm		22b. DATE SIGNED 12-27-60		22c. PHYSICIAN'S NAME (Type) Dr. Ilse Kamm		22d. ADDRESS Sykesville, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/29/1960		23c. NAME OF CEMETERY OR CREMATORY Grace Church Cemetery		23d. LOCATION (City, town, or county) (State) Elkridge, Md.		24. FUNERAL DIRECTOR'S SIGNATURE Easton Funeral Home		25a. REC'D BY REGISTRAR DATE JAN 4 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kram	

bp

192

M

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MEDICAL CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13682

13651

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3mo. 1da.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
3. NAME OF DECEASED (Type or print) J. Maryline Josephine Dolan		4. DATE OF DEATH Month December		Day 7		Year 19 60		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 8, 1887		9. AGE (In years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME John Connell		14. MOTHER'S MAIDEN NAME Bridget Cowley		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield State Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple abscesses in lungs and kidneys DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Probable septicemia DUE TO (c) Infected decubitus ulcers		INTERVAL BETWEEN ONSET AND DEATH days weeks		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circulatory disturbance, with psychotic reaction		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 19		20g. (County) 19		20h. (State) 19		20i. (City or town) 19		20j. (County) 19	
20k. (State) 19		20l. (City or town) 19		20m. (County) 19		20n. (State) 19		20o. (City or town) 19	
20p. (County) 19		20q. (State) 19		20r. (City or town) 19		20s. (County) 19		20t. (State) 19	
20u. (City or town) 19		20v. (County) 19		20w. (State) 19		20x. (City or town) 19		20y. (County) 19	
20z. (State) 19		20aa. (City or town) 19		20ab. (County) 19		20ac. (State) 19		20ad. (City or town) 19	
20ae. (County) 19		20af. (State) 19		20ag. (City or town) 19		20ah. (County) 19		20ai. (State) 19	
20aj. (City or town) 19		20ak. (County) 19		20al. (State) 19		20am. (City or town) 19		20an. (County) 19	
20ao. (State) 19		20ap. (City or town) 19		20aq. (County) 19		20ar. (State) 19		20as. (City or town) 19	
20at. (County) 19		20au. (State) 19		20av. (City or town) 19		20aw. (County) 19		20ax. (State) 19	
20ay. (City or town) 19		20az. (County) 19		20ba. (State) 19		20bb. (City or town) 19		20bc. (County) 19	
20bd. (State) 19		20be. (City or town) 19		20bf. (County) 19		20bg. (State) 19		20bh. (City or town) 19	
20bi. (County) 19		20bj. (State) 19		20bk. (City or town) 19		20bl. (County) 19		20bm. (State) 19	
20bn. (City or town) 19		20bo. (County) 19		20bp. (State) 19		20bq. (City or town) 19		20br. (County) 19	
20bs. (State) 19		20bt. (City or town) 19		20bu. (County) 19		20bv. (State) 19		20bw. (City or town) 19	
20bx. (County) 19		20by. (State) 19		20bz. (City or town) 19		20ca. (County) 19		20cb. (State) 19	
20cc. (City or town) 19		20cd. (County) 19		20ce. (State) 19		20cf. (City or town) 19		20cg. (County) 19	
20ch. (State) 19		20ci. (City or town) 19		20cj. (County) 19		20ck. (State) 19		20cl. (City or town) 19	
20cm. (County) 19		20cn. (State) 19		20co. (City or town) 19		20cp. (County) 19		20cq. (State) 19	
20cr. (City or town) 19		20cs. (County) 19		20ct. (State) 19		20cu. (City or town) 19		20cv. (County) 19	
20cw. (State) 19		20cx. (City or town) 19		20cy. (County) 19		20cz. (State) 19		20da. (City or town) 19	
20db. (County) 19		20dc. (State) 19		20dd. (City or town) 19		20de. (County) 19		20df. (State) 19	
20dg. (City or town) 19		20dh. (County) 19		20di. (State) 19		20dj. (City or town) 19		20dk. (County) 19	
20dl. (State) 19		20dm. (City or town) 19		20dn. (County) 19		20do. (State) 19		20dp. (City or town) 19	
20dq. (County) 19		20dr. (State) 19		20ds. (City or town) 19		2			

Burial Dec. 12/60 ARLINGTON NATIONAL CEM.- ARLINGTON, VIRGINIA

Mary Josephine

13082

CERTIFICATE OF DEATH

13082

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
13683

DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13652

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt Airy - Rural</u>		c. LENGTH OF STAY IN 1b <u>1 week</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridge Road</u>				d. STREET ADDRESS <u>3316 Garrison Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Joseph</u> Last <u>Dougherty</u>				4. DATE OF DEATH Month <u>December</u> Day <u>5</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20, 1901</u>		9. AGE (In years lost birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painter</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Joseph Dougherty</u>				14. MOTHER'S MAIDEN NAME <u>Mary J. Flaherty</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-05-4141</u>		17. INFORMANT <u>William J. Dougherty, Jr. Mt. Airy, Md.</u> Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Arterio sclerotic Heart Disease</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>2-3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>—</u> p. m. <u>—</u> 19 <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 1960</u> to <u>—</u> 19 <u>—</u> , that (I) (we) last saw the deceased alive on <u>Dec. 4</u> 19 <u>60</u> , and that death occurred at <u>9:45</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>W.B. Culwell</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/5/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.B. Culwell M.D.</u>				22d. ADDRESS <u>Mount Airy, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 9, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>E. Vernon Lemmon</u>				ADDRESS <u>4611 Park Heights, Balto. Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 9 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles L. Throck</u>			

BP

1988

CERTIFICATE OF DEATH

1988

1988

1988

CERTIFICATE OF DEATH

Reg. Dist. No. 13653

13684

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) REESE				c. LENGTH OF STAY IN 1b 2 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WESTMINSTER RD #4				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DAISY MAY BLOOM DULL				4. DATE OF DEATH Month DEC. Day 20 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 12 1889	
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME JASPER L. BLOOM				14. MOTHER'S MAIDEN NAME ELLA HORTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT CHARLES DULL REESE MARYLAND (HUSBAND)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) ARTERIO SCLEROSIS CARDIOVASCULAR DIS. 2 YEARS DUE TO (c) DIABETES MELLITUS INTERVAL BETWEEN ONSET AND DEATH 10 WEEKS INDEFINITE							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from OCTOBER 1959 , to DECEMBER 1960 , that I last saw the deceased alive on DECEMBER 20 1960 , and that death occurred at 9:12 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Daniel I. Welliver M.D.				ADDRESS (Street, city or town, state) 19 RIDGE ROAD DATE SIGNED 12-20-60			
PHYSICIAN'S NAME (Type) DANIEL I. WELLIVER				WESTMINSTER MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		12/23/60		Westminster Cemetery Westminster Md.			
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers, Jr. Westminster, Md.				24a. REC'D BY REGISTRAR DATE DEC 27 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13685

13654

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>7809 Boston Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Florence Agnes Edwards</u>		4. DATE OF DEATH <u>12-11-1960</u>	
5. SEX <u>Fem.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-21-1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gift shop & dress shop</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Leonard Edwards</u>		14. MOTHER'S MARRIED NAME <u>Myra Travis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Springfield Hosp. Records.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome with Cerebral Arteriosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>3-17-1939</u> to <u>12-11-1960</u> , that (I) (we) last saw the deceased alive on <u>12-11-1960</u> and that death occurred at <u>P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Konstantin Weber</u>		22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type) <u>Konstantin WEBER</u>		22d. ADDRESS <u>Oak Street, Sykesville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/16/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>DEC 21 '60</u>	
ADDRESS <u>Silver Spring, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13666

13655

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. LENGTH OF STAY IN 1b <u>4 1/2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>		03X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Longview Nursing Home</u>				d. STREET ADDRESS <u>Old York Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Serena</u> Middle <u>M.</u> Last <u>Enfield</u>			4. DATE OF DEATH Month <u>December</u> Day <u>6</u> Year <u>1960</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 4 1881</u>		9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Meredith</u>			14. MOTHER'S MAIDEN NAME <u>Laura Wilson</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs J. Chas. Pierce, White Hall Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio Vascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>?</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-18-1960</u> to <u>12-6-1960</u> , that (I) (we) last saw the deceased alive on <u>12-5-1960</u> , and that death occurred at <u>1:30 P.</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph E. Bush</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-6-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>				22d. ADDRESS <u>Hampstead Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-9-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>West Liberty Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>White Hall, Balto Co, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hartenstein</u>				ADDRESS <u>New Freedom, Pa.</u>		25a. REC'D BY REGISTRAR <u>DEC 9 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
13686 CERTIFICATE OF DEATH 13656									
1. PLACE OF DEATH a. COUNTY Carroll Middleburg MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middleburg					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brookfield Manor Nursing Home					d. STREET ADDRESS Middleburg, Md			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sterling Duray Evans					4. DATE OF DEATH Month Day Year December 26 1960				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/7/12		9. AGE (In years last birthday) 48 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Westminster, Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John H. Evans					14. MOTHER'S MAIDEN NAME Lillian Barber				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 213-0191874		17. INFORMANT Mrs. Evans			Address Westminster, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma DUE TO 345X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3 years								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from October 1, 1960 to Dec 26, 1960 that (I) (we) last saw the deceased alive on Dec 26, 1960 and that death occurred at 3:30 P.M. from the causes and on the date stated above.									
22a. SIGNATURE J. H. Messler		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Dec 27, 1960	
22c. PHYSICIAN'S NAME (Type) J. H. MESSLER, M.D.		22d. ADDRESS Union Bridge, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/29/60		23c. NAME OF CEMETERY OR CREMATORY Evergreen Mem. Gardens		23d. LOCATION (City, town, or county) (State) Finksburg Md			
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers, Jr		ADDRESS Willis & Longwell Ave		25a. REC'D BY REGISTRAR JAN 3 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

18088

CERTIFICATE OF DEATH

18088

Decedent	John H. Evans	Age	48	Sex	Male	Color	White	Marital Status	Married	Place of Birth	Brookfield, Mass.	Usual Residence	Brookfield, Mass.	Occupation	Farmer	Signature of Physician	Wm. H. Evans	Signature of Registrar	Wm. H. Evans
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Witnesses: Wm. H. Evans, John H. Evans

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13657

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 4 mos. 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Cora Middle May Last Wardell				4. DATE OF DEATH Month December Day 30 , Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 29, 1882	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant in girls school				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Wardell				14. MOTHER'S MAIDEN NAME Mary Lenthard Lennord			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No				16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia (atrial fibrillation) 433.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 5 hrs. Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from August 29, 1960 to Dec. 30, 1960 , that (I) (we) last saw the deceased alive on Dec. 29, 1960 , and that death occurred at 6:30 AM from the causes and on the date stated above.							
22a. SIGNATURE J. Raymond Gladue				22b. DATE SIGNED 12/30/60			
22c. PHYSICIAN'S NAME (Type) J. Raymond Gladue, M.D.				22d. ADDRESS Springfield Hospital, Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-3-61		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				25a. REC'D BY REGISTRAR DATE JAN 4 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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DEPT. OF STATE

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OFFICE OF THE SECRETARY OF STATE

WASHINGTON, D. C.

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13688

13658

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Littletown Pa. RD#1</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Littletown Pa. RD#1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Black School Road</u>				d. STREET ADDRESS <u>Black School Road</u>			
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>VIRGINIA</u> Last <u>GREEN</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>31</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 4, 1873</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Zachariah Conaway</u>				14. MOTHER'S MAIDEN NAME <u>Margaret A. Knight</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Claude A. Green, Littletown RD#1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis (general) c</u> DUE TO <u>Hypertension & Coronary Sclerosis</u> (c) <u>Splenitis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>Several yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 19 56</u> to <u>Dec 31, 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec 31, 1960</u> and that death occurred at <u>10:35 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>W. Glenn Speicher</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/31/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. GLENN SPEICHER MD</u>				22d. ADDRESS <u>Westminster Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/4/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant Cemetery Rural, Westminster Md</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Meyer, Jr. Westminster Md</u>				ADDRESS <u>-</u>		25a. REC'D BY REGISTRAR <u>JAN 4 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>			

13638

STATE OF DEATH

13638

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13689

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13659

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Carroll</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Sykesville</i>				c. LENGTH OF STAY IN 1b <i>Life</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>Arthur Ave.</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Lillian</i> First <i>MAE</i> Middle <i>GREEN</i> Last				4. DATE OF DEATH <i>Dec.</i> Month <i>16</i> Day <i>19</i> Year <i>60</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 20, 1905</i>	9. AGE (In years lost birthday) <i>55</i> yrs.	IF UNDER 1 YEAR: Months <i>16</i> Days <i>19</i> Hours <i>00</i> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>							
13. FATHER'S NAME <i>Harry Green</i>				14. MOTHER'S MAIDEN NAME <i>Carrie Trugler</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Mr. Frank Green - Arthur Ave. Sykesville, Md.</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute Cardiac failure</i> DUE TO <i>157x</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Bronchopneumonia</i> DUE TO <i>Carcinoma of Pancrea</i> (c) <i>49 yrs.</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>1 wk.</i> (b) <i>2 day.</i> (c) <i>49 yrs.</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan. 1958</i> to <i>Dec. 16, 1960</i> , that (I) (we) last saw the deceased alive on <i>12-16-1960</i> and that death occurred at <i>4:30 P.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>R. V. Houck Jr.</i>				22b. DATE SIGNED <i>12-17-60</i>			
22c. PHYSICIAN'S NAME (Type) <i>R. V. HOUCK, JR.</i>				22d. ADDRESS <i>LIBERTY RD. SYKESVILLE, M.D.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-19-60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>New Oakland</i>		23d. LOCATION (City, town, or county) (State) <i>Oakland Rd. Carroll Co., Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Luther A. Haight Sykesville, Md.</i>				25a. REC'D BY REGISTRAR <i>DEC 21 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

1900

CERTIFICATE OF DEATH

1900

MADE IN U.S.A.

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13690

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13660

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 24			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anna Middle Vilma Last Gresdo				4. DATE OF DEATH Month 12 Day 4 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1882	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min.	IF UNDER 24 HRS. Months 78 Days 78 Hours 78 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? Czechoslovakia	
13. FATHER'S NAME John PORUBSKY				14. MOTHER'S MAIDEN NAME Catherine HUSAR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-07-1287B		17. INFORMANT Springfield Hospital Records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease 4-20-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. due to arteriosclerotic brain disease						INTERVAL BETWEEN ONSET AND DEATH years years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-7-60 to 12-4-60 , that (I) (we) last saw the deceased alive on 12-4-1960 and that death occurred at 4:45 M. from the causes and on the date stated above.							
22a. SIGNATURE J. Raymond Gladue, M.D.				22b. DATE SIGNED DEC 7 '60		22c. PHYSICIAN'S NAME (Type) J. Raymond Gladue, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 12-7-60		23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEM.	
24. FUNERAL DIRECTOR'S SIGNATURE Chas S. Zeiler				25a. REC'D BY REGISTRAR DEC 7 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

OP

RESEARCH AND DEVELOPMENT

1981



1
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13691
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
13661
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2 wks.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Central and 3rd Sts.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALICE V. GUE		4. DATE OF DEATH December 5, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1875
9. AGE (In years lost birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Asbury Burdette		14. MOTHER'S MAIDEN NAME Elizabeth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mrs. Stanley D. Maxley,		Address Same as 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Cardiac failure, pulmonary edema. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease, Atherosclerosis DUE TO (c) Generalized		INTERVAL BETWEEN ONSET AND DEATH 1957 to 5 Dec 60	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1959 to 5 Dec 1960 , that (I) (we) last saw the deceased alive on 5 Dec 1960 , and that death occurred at 6:30 P. from the causes and on the date stated above.			
22a. SIGNATURE Howard E. Hall		22b. DATE SIGNED 6 Dec 60	
22c. PHYSICIAN'S NAME (Type) Howard E. Hall, M. D.		22d. ADDRESS Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-7-1960	
23c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery		23d. LOCATION (City, town, or county) (State) Mt. Airy, Carroll, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Maryland		25a. REC'D BY REGISTRAR DEC 7 '60	
25b. REGISTRAR'S SIGNATURE L. K. K.			

13001

CERTIFICATE OF DEATH

13001

County

State

City

Age

Sex

Color

Marital

Occupation

Education

Religion

Birth

Death

Date of Death

Place of Death

Cause of Death

Manner of Death

Signature

Witness

Physician

Medical Examiner

No.

Signature of Medical Examiner

Signature of Physician

Signature of Witness



Signature of Medical Examiner

Signature of Physician

Signature of Witness

Signature of Medical Examiner

Signature of Physician

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13692

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13662

1. PLACE OF DEATH a. COUNTY Carroll			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 5 mo. - 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital, Sykesville			d. STREET ADDRESS 4802 Althea Ave., Balto. #6		
3. NAME OF DECEASED (Type or print) George Christopher HALLMEYER			4. DATE OF DEATH 12 10 1960		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-13-89	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Linotype operator			10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Frank A. Hallameyer			14. MOTHER'S MAIDEN NAME Ann Christine AMREIN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes First 1919			16. SOCIAL SECURITY NO. 213-07-7807		
17. INFORMANT Springfield Hospital, Sykesville, Maryland			18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction of the colon. 570.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Embolic of the mesenteric veins. DUE TO (c) Healing of right femur after surgical procedure.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS assoc. with senile brain disease with psychotic reaction.					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY 3:40 a.m. Month, Day, Year 10-18 1960			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital- Ward			20f. (City or town) (County) (State) Sykesville, Carroll Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE JAMES T. Marsh			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) James T. Marsh, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			DATE SIGNED 12/10/60		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 12/13/60		
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer			22d. LOCATION (City, town, or country) (State) Balto Md		
23. FUNERAL DIRECTOR Leonard S. Ruck			24a. REC'D BY REGISTRAR 5305 Hartford Rd		
			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

13803

13803

THE CASE
NUMBER

1

13803

13803

13803

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13667 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13506

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Carroll</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> <u>Carroll</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u>		c. LENGTH OF STAY IN 1b <u>Unknown</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Mt. Airy</u>		d. STREET ADDRESS <u>- - -</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Mount Airy</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Joseph</u>		First <u>Joseph</u> Middle <u>R.</u> Last <u>Hess</u>		4. DATE OF DEATH <u>Dec. 22</u>		Day <u>22</u> Year <u>60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-21-1889</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Hess</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Eshelman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes give war or dates of service) <u> </u>		17. INFORMANT <u> </u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>422.01</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20d. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				22. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <u>James T. Marsh</u>		M.D. <u> </u>		DATE SIGNED <u>12/22/60</u>		DEPUTY MEDICAL EXAMINER (Street, city, town, or county) <u>CARROLL</u>	
EXAMINER'S NAME (Type) <u>JAMES T MARSH</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-27-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery, Arlington, Va.</u>	
23. FUNERAL DIRECTOR <u>Joseph Gaudin's Sons Inc. 1756 Park Ave NW</u>		ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

1556

1556



1556

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

13693

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13663

Item 1 Film 278 1-3-61

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		MARYLAND c. LENGTH OF STAY IN 1b 6 Mos. 20 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 5431 Hilltop Ave.	
3. NAME OF DECEASED (Type or print) First Lewis Middle Frederick Last Justice		4. DATE OF DEATH Month December Day 21 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 21, 1882	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House painter		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William E. Justice		14. MOTHER'S MAIDEN NAME Mary Carter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Coronary artery disease DUE TO (c) C.B.S. assoc. with cerebral arteriosclerosis without qualifying phrase.					INTERVAL BETWEEN ONSET AND DEATH 4 days Years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis without qualifying phrase.					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Manth. Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Springfield Hospital, Sykesville, Md.	
20f. (City or town) Springfield Hospital, Sykesville, Md.		20g. (County) Baltimore Co.		20h. (State) Maryland	
21. I certify that (I) (this hospital) attended the deceased from June 1, 1960 , that (I) (we) last saw the deceased alive on December 20, 1960 and that death occurred on December 21, 1960 at 5:20 AM from the causes and on the date stated above.					
22a. SIGNATURE Agustin del Campo		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12/21/60	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 24, 1960		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
23d. LOCATION (City, town, or county) Baltimore Co.		23e. (State) Maryland		23f. (Country) U.S.A.	
24. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc.		ADDRESS 1217 St. Paul Street		25a. REC'D BY REGISTRAR DEC 27 '60 DATE	
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas					

18083

EXHIBIT A OF DEATH

18083

TO THE HONORABLE

THE JUDGE OF THE

COURT OF COMMONS

IN THE CITY OF

NEW YORK

IN MATTER OF

THE ESTATE OF

JOHN J. ...

DECEASED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13664

13694

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY V			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 2 years 4 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore #7		3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 5206 Gwynn Oak Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Katherine Elizabeth Shipley Middle KELLER Last KELLER				4. DATE OF DEATH Month 12 Day 23 Year 1960			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-6-75	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 85 Days ##	IF UNDER 24 HRS. Hours ## Min. ##	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Taylor Shipley				14. MOTHER'S MAIDEN NAME Emma Bowen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT Address Springfield State Hosp., Sykesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Old rheumatic heart disease with passive congestion. DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH days years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with senile brain disease, with psychotic reaction.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 8-7-59 , 19____, to 12-23-60 , 19____, that I last saw the deceased alive on 12-23-60 , 19____, and that death occurred at 9p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 12-24-60							
ACTUAL SIGNATURE Ellis S. Margolin M.D.							
PHYSICIAN'S NAME (Type) Ellis Margolin, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 26, 1960	22c. NAME OF CEMETERY OR CREMATORY Stone Chapel Cemetery	22d. LOCATION (City, town, or county) (State) Balto. Co. Md.				
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Callaway & Associates 4600 Liberty Heights Avenue				24a. REC'D BY REGISTRAR DATE DEC 28 '60	24b. REGISTRAR'S SIGNATURE Arthur S. K...		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18881

CERTIFICATE OF DEATH

18881

DECEASED

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

DECLARATION OF DEATH
I, the undersigned, being a duly qualified medical practitioner, do hereby certify that the above-named person has died at the place of death stated above, and that the cause of death is as stated above.

Signed: _____
Date: _____

Witness: _____
Date: _____

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other person is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13668 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13665

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>46 years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>61 Penna. Ave.</u>				d. STREET ADDRESS <u>161 Penna. Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELTINGE LEVINE KING</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 4 1904</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Westminster, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward F. King</u>				14. MOTHER'S MAIDEN NAME <u>Louise Stansbury</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mr. Edw. F. King, Westminster, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>min</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James J. Marsh</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>11/14/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Kridders Cemetery</u>	
22d. LOCATION (City, town, or country) (State) <u>Rural Westminster Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>			
23. FUNERAL DIRECTOR <u>J. E. Myers, Jr., Westminster, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 13 '60</u>			

MEDICAL CERTIFICATION

2

DATE SIGNED

12/11/60

RECEIVED
FEB 10 1960

13008

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1000

1

1. Name of Deceased: John J. Smith

2. Sex: Male

3. Age: 45

4. Date of Death: Jan 15, 1960

5. Place of Death: Home

6. Cause of Death: Myocardial Infarction

7. Manner of Death: Natural

8. Signature of Medical Examiner: Dr. J. H. Smith

9. Signature of Coroner: John J. Smith

10. Signature of Registrar: John J. Smith

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13695

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13666

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville c. LENGTH OF STAY IN 1b 8 yrs. 5 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore, Md. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3001-4 d. STREET ADDRESS 3821 Garrison Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Isador Jacob Kirsh		4. DATE OF DEATH Month 12 Day 7 Year 19 60		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-29-08		9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 5 Days 19		11. IF UNDER 24 HRS. Hours 19 Min. 60			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic				10b. KIND OF BUSINESS OR INDUSTRY Maryland				11. BIRTHPLACE (State or foreign country) USA				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Louis Kirsh				14. MOTHER'S MAIDEN NAME Rose Miller				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Records Springfield Hospital 1 (State)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 300.3 DUE TO occlusion of larynx with food Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) 300.3 DUE TO occlusion of larynx with food (c) 300.3																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Schizophrenia Reaction, Paranoid type																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 12/9/60				22c. NAME OF CEMETERY OR CREMATORY Agudath Chaim Cong.				22d. LOCATION (City, town, or country) (State) Baltimore, Md.							
23. FUNERAL DIRECTOR SOL LEVINSON & BROS INC. 6010 Reisterstown Rd.				24a. REC'D BY REGISTRAR DEC 12 '60				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				24c. DATE SIGNED 12/7/60							

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

EXAMINER'S NAME (Type or print)

James L. Marsh

JAMES L. MARSH

M.D.

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED

12/7/60

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TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
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13697

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13668

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1yr. 4mo. 20da.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 13		d. STREET ADDRESS 3432 Chesterfield Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Fred Middle William Last Klingmeyer		4. DATE OF DEATH Month December Day 6 Year 1960		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 10, 1893		9. AGE (In years last birthday) 67		IF UNDER 1 YEAR Months 6 Days 1 Hours 4 Min. 4									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Balto. Transit Operator		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry Klingmeyer		14. MOTHER'S MAIDEN NAME Sophia Volk		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-10-0926		17. INFORMANT Springfield State Hospital Records							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, right lung, pyogenic, type undetermined. DUE TO (b) 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. of Unknown or Unspecified Cause with Psychotic Reaction.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from July 16, 1959 to December 6, 1960 , that (I) (we) last saw the deceased alive on December 5, 1960 , and that death occurred at 12:35 A.M. from the causes and on the date stated above.		22a. SIGNATURE Agustin del Campo M.D.		22b. DATE SIGNED 12-6-60		22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 9/60		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem		23d. LOCATION (City, town, or county) (State) Baltimore Co		24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road		25a. REC'D BY REGISTRAR DEC 8 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

CERTIFICATE OF DEATH

13669

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Md.		c. LENGTH OF STAY IN 1b 51 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hosp.		d. STREET ADDRESS 1313 Asquith St.	
3. NAME OF DECEASED (Type or print) Annie First Name O. Middle Knight Last		4. DATE OF DEATH 12 26 60 Month Day Year	
5. SEX Fem.		6. COLOR OR RACE W.	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/18/86 not listed	
9. AGE (In years last birthday) 74 74 Yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Theodore H. Knight		14. MOTHER'S MAIDEN NAME Elizabeth Hein	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction 570.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Volvolus of the colon (c) Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH 1 day 2 days Less than day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1958 to Dec. 26 1960 , that (I) (we) last saw the deceased alive on Dec 26 1960 , and that death occurred at 3:15 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Ellis S. Margolin M.D.		22b. DATE SIGNED 12/27/60	
22c. PHYSICIAN'S NAME (Type) ELLIS S. MARGOLIN		22d. ADDRESS Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 12-30-60	
23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		25. REC'D BY REGISTRAR DEC 29 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. House			

13008

CERTIFICATE OF DEATH

13008

Blank certificate form with horizontal lines for text entry.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
13699
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
13670

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>11 ms. 8 das</u> 27 <u>Westminster</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>462 E. Green St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edith Hannah Kress Lambert</u>		4. DATE OF DEATH Month Day Year <u>December 12 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 12, 1876</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leonard Kress</u>		14. MOTHER'S MAIDEN NAME <u>Mannah Keefer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Springfield Hospital records.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Infected decubital ulcers</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. assoc. with senile brain disease with psychotic reaction.</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 4 1960</u> to <u>December 12 1960</u> , that (I) (we) last saw the deceased alive on <u>December 10 60</u> , and that death occurred at <u>1A M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>J. Raymond Gladue</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>J. Raymond Gladue, M.D.</u>		22d. ADDRESS <u>Springfield Hospital, Sykesville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/14/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Winters Cemetery Rural New Windsor, Md.</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr. Westminster, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 15 '60</u>	
ADDRESS <u>Westminster, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Circling L. Hump</u>	

13030

CERTIFICATE OF DEATH

13030

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13700 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13671

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 6mo. 21da. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 11 d. STREET ADDRESS 2621 Elm Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bessie Amanda Langley		4. DATE OF DEATH Month December Day 9 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1880
9. AGE (in years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 0 Days 21	11. IF UNDER 24 HRS. Hours 0 Min. 0
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -	
13. FATHER'S NAME Lloyd Kidd		14. MOTHER'S MAIDEN NAME Susan Raleigh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield State Hospital Records		Address Springfield State Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis, acute, secondary to 606X DUE TO Conditions, if any, which gave rise to immediate cause (b) Pelvic abscess (a), stating the underlying cause last. DUE TO (c) Perforation of infected diverticula of urinary bladder PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractured femur. C.B.S. assoc. with cerebral arteriosclerosis, with psychotic reaction			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 days	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slipped and fell to floor	
21. TIME OF INJURY Month, Day, Year 12:45 A.M. 10-4-60		22. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Springfield Hosp.		24. (City or town) (County) (State) Sykesville, Carroll, Maryland	
25. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James T. Marsh EXAMINER'S NAME (Type) James T. Marsh, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12-9-60	
26a. BURIAL, CREMATION, REMOVAL (Specify) Burial		26b. DATE THEREOF 12/12/60	
26c. NAME OF CEMETERY OR CREMATORY Pine Grove		26d. LOCATION (City, town, or country) (State) Balto Co	
27. FUNERAL DIRECTOR Caul Chenoweth		28. ADDRESS Chestnut Ave.	
29. REC'D BY REGISTRAR DEC 15 '60		30. REGISTRAR'S SIGNATURE Arthur L. Hanes	

MEDICAL CERTIFICATION

18700

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18700

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13669

13672

1. PLACE OF DEATH a. COUNTY <u>Carmel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carmel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> 27	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>75 Bond St.</u>		d. STREET ADDRESS <u>75 Bond St. 1</u>	
3. NAME OF DECEASED (Type or print) <u>LESTER</u> First <u>HOWARD</u> Middle <u>LEGORE</u> Last		4. DATE OF DEATH <u>Dec.</u> Month <u>30</u> Day <u>1960</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 21 1900</u> 60 yrs.
9. AGE (In years lost birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nat. Retail Salesman (labor worked in factory)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Adams Co. Pa.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Howard W. Legore</u>		14. MOTHER'S MAIDEN NAME <u>Adeline Bowers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-01-1912</u>	
17. INFORMANT <u>Mr. Lester H. Legore, Westminster</u>		Address <u>75 Bond St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary insufficiency</u> DUE TO (c) <u>months</u>		INTERVAL BETWEEN ONSET AND DEATH <u>months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 16</u> 19 <u>60</u> , to <u>Dec 30</u> 19 <u>60</u> , that (I) (we) lost saw the deceased alive on <u>Dec 27</u> 19 <u>60</u> , and that death occurred at <u>3AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>James T. Marsh</u>		22b. DATE SIGNED <u>12/31/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u>		22d. ADDRESS <u>Westminster Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/2/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Brygreen Memorial Gardens</u>		23d. LOCATION (City, town, or county) (State) <u>Timberbury, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Smyers Jr.</u>		25a. REC'D BY REGISTRAR <u>Jan 4 '61</u>	
ADDRESS <u>Westminster, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Finner</u>	

1903

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS - CANE HUNT, TEXAS

CERTIFICATE OF DEATH

1903

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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13701
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13673

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>8 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Josephine Matusky LLOYD</u>				4. DATE OF DEATH Month Day Year <u>12 - 26 - 1960</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-15-77</u>	
9. AGE (In years lost birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Austria</u>			
13. FATHER'S NAME <u>EMERICK</u> <u>Emrick Matusky</u>				14. MOTHER'S MAIDEN NAME <u>Johanna Thorne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Springfield State Hospital, Sykesville, Md.</u>			
17. INFORMANT Address <u>Springfield State Hospital, Sykesville, Md.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Arteriosclerotic heart disease.</u> DUE TO <u>years</u> (c) <u>cerebral CBS assoc. with arteriosclerosis.</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			
20c. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>				20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20e. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12-19-60</u> to <u>12-26</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>12-26-60</u> 19 <u>60</u> , and that death occurred at <u>1:55 a.m.</u> M, from the causes and on the date stated above.				22a. SIGNATURE <u>Ellis S. Margolin</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>12-26-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Ellis S. Margolin, M.D.</u>				22d. ADDRESS <u>Sykesville, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>12/29/60.</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>7401 German Hill Rd. Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles A. Zailer</u> ADDRESS <u>6224 Eastern Ave. BALTO., 24, MD.</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 29 '60</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>							

1873

CERTIFICATE OF ORIGIN

1873

✓



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

13702

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13674

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS -	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William Edgar Lutz		4. DATE OF DEATH December 2 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 23, 1877
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night watchman		10b. KIND OF BUSINESS OR INDUSTRY creamery -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown John L. Lutz		14. MOTHER'S MAIDEN NAME Unknown Amanda McBride	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-09-7664	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 4 46X IMMEDIATE CAUSE (a) Bilateral bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Nephrosclerosis, bilateral DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with cerebral arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from November 9 19 60 to December 2 19 60 , that (I) (we) last saw the deceased alive on December 2 1960 , and that death occurred at 12:20 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 12-2-60	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
22b. DATE THEREOF 12/5/1960		23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery	
23d. LOCATION (City, town, or county) Middletown		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus		25a. REC'D BY REGISTRAR DEC 6 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

13708

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Signature of medical officer: _____

9. Signature of registrar: _____

10. Date of registration: _____

20550 11/11/12

13703

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13675

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>			
c. LENGTH OF STAY IN 1b <u>5 years</u>				d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HARRY HERBERT MacLELLAN</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>14</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 31, 1892</u>		9. AGE (In years last birthday) <u>68</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Building Estimator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John MacLellan</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WWI</u>			
16. SOCIAL SECURITY NO. <u>216-07-7490</u>				17. INFORMANT Address <u>Mrs Edith MacLellan - Sykesville, md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> 151X DUE TO <u>Carcinoma of stomach</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1 day</u> (c) <u>1 yr</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>ACVD and Coronary infarction → Cardiac failure</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>June 1958</u> to <u>Dec 1960</u> , that (I) (we) lost saw the deceased alive on <u>Dec 14 1960</u> , and that death occurred at <u>1:20 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>R.V. Houck, Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-14-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>R.V. Houck, Jr.</u>				22d. ADDRESS <u>LIBERTY RD. SYKESVILLE, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-16-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>		23d. LOCATION (City, town, or county) (State) <u>Sykesville, md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u>				25a. REC'D BY REGISTRAR <u>DEC 19 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

bp

15175

CERTIFICATE OF DEATH

15175

March 1942

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
13704 CERTIFICATE OF DEATH 13676									
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frizelburg			c. LENGTH OF STAY IN 1b 40 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frizelburg				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Walter Last Marker					4. DATE OF DEATH Month December Day 22 Year 1960				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 18, 1895		9. AGE (In years last birthday) 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Oil Company		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles S. Marker					14. MOTHER'S MAIDEN NAME Cora Segafosse				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-03-5950		17. INFORMANT Mrs. Alice Marker, Westminster, Md. R.D.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 157X IMMEDIATE CAUSE (a) Carcinoma head of pancreas DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 mos								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug 15 1960 , to Dec 22 1960 , that (I) (we) last saw the deceased alive on Dec 22 1960 , and that death occurred 11:55 PM , from the causes and on the date stated above.									
22a. SIGNATURE Julius Chepko		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/29/60					
22c. PHYSICIAN'S NAME (Type) Julius Chepko		22d. ADDRESS 85 E. W. G. Street Westminster, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 26, 1960		23c. NAME OF CEMETERY OR CREMATORY Baust Church Cemetery		23d. LOCATION (City, town, or county) (State) Tyrone, Carroll Co. Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE C.O. Fuss & Son				ADDRESS Taneytown, Maryland		25a. REC'D BY REGISTRAR DEC 27 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Huns	

13304

CERTIFICATE OF BIRTH

13304

Constitutional physician

*Johns Hopkins
Baltimore, Md.*

*875 West 12th St
New York, N.Y.*

13705

CERTIFICATE OF DEATH

Reg. Dist. No. 13677

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millers</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millers</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>EMMA - L - McGEHE</u> First Middle Last		4. DATE OF DEATH <u>Dec 1</u> Month Day Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-25-1874</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Hasfeld</u>		14. MOTHER'S MAIDEN NAME <u>Regina Gunther</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Hypostatic pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Hemorrhage</u> DUE TO <u>Cerebral Hemorrhage</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>50</u> , to <u>Dec 1</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>11-18</u> , 19 <u>60</u> , and that death occurred at <u>9:10 A</u> M, from the causes on and on the date stated above.			
ACTUAL SIGNATURE <u>W H Foard</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Manchester, Md 12-1-60</u>	
PHYSICIAN'S NAME (Type) <u>W H Foard M.D.</u>		<u>Manchester, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-4-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Seaside Lutheran</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Shipton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Wm S. Foard</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

87 240MFLA=MFL:3M44-2-3M499-2-12 01A-Y25

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13706 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13678

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY in 1b <u>Life</u>		X c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R6</u>				d. STREET ADDRESS <u>R6</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Douglas ADAM McQuay</u>				4. DATE OF DEATH Month <u>12</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>Sm</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 8 - 60</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>(Balt.) Maryland</u>		9. AGE (In years last birthday) yrs. <u>1</u> Months <u>24</u> Days <u></u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
13. FATHER'S NAME <u>Francis C. McQuay</u>				14. MOTHER'S MAIDEN NAME <u>Jane E. Burns</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Francis C. McQuay - Westminster Md</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undetermined</u> <u>795.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James J. Marsh</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12-2-60</u>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u></u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-5-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rabbi Isaac Memorial Park</u>		22d. LOCATION (City, town, or country) (State) <u>Rehoboth Road, Hykesville, Md.</u>	
23. FUNERAL DIRECTOR <u>Arthur H. Haight</u>				ADDRESS <u>Hykesville, Md.</u>		24e. REC'D BY REGISTRAR <u>DEC 6 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

239193 XVS

1873

1873 MEDICAL EXAMINER CERTIFICATE OF DEATH

THE STATE
OF NEW YORK



[Faint, mostly illegible text from the reverse side of the document, including names and dates.]

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13707

CERTIFICATE OF DEATH

13679

Item 1 Film 219 1-12-61 et

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fayetteville</u>		c. LENGTH OF STAY IN 1b <u>3 Yrs. 1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Springfield State Hospital</u>		e. STREET ADDRESS <u>3433 University Place</u>	
3. NAME OF DECEASED (Type or print) <u>Richard Walter Miller</u>		4. DATE OF DEATH <u>Decem. 31 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2-19-1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager of food co</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>—</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William E. Miller</u>		14. MOTHER'S MAIDEN NAME <u>Anna White</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records from Spring. State Hospital</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis and marked obesity</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mental Dis. Schizophrenic reaction par. type</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>7-1</u> <u>1953</u> to <u>12-30</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>12-30</u> <u>1960</u> , and that death occurred at <u>9:40 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Myron Nizankowsky</u>		22b. DATE SIGNED <u>—</u>	
22c. PHYSICIAN'S NAME (Type) <u>Myron Nizankowsky</u>		22d. ADDRESS <u>Springfield State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 3, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell & Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>Jan 3 '61</u>	
ADDRESS <u>1900 Eutaw Place</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

1870

CERTIFICATE OF DEATH

1870

[Faint, mostly illegible handwritten text, likely a death certificate form. Visible fragments include:]

... of ...
... born ...
... died ...
... cause of death ...
... signed ...
... witness ...
... registrar ...

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
5M 7/59

13708 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13680

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN TB <u>15 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		d. STREET ADDRESS <u>102 Melrose St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Forrest</u> Last <u>Myers, JR.</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-9-15</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months <u>15</u> Days <u>12</u>		IF UNDER 24 HRS. Hours <u>15</u> Min. <u>12</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Paul Myers</u>				14. MOTHER'S MAIDEN NAME <u>Mae Holt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Hospital records</u> Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation</u> <u>353.3</u> DUE TO (b) <u>Epilepsy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>154-1-</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James J. Marsh</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>12-12-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/14/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR <u>Joseph Gunkles Sons</u>				ADDRESS <u>1756 PA. AVE., N.W., DC (6)</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 14 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>James J. Marsh</u>			

0680

18308 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE STATE OF NEW YORK

[Faint, mostly illegible text from the reverse side of the document, appearing as bleed-through.]

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
13709
CERTIFICATE OF DEATH
13681

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN lb 8 months d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3921 Keswick Rd., Balto. #11 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Emily Fischer OFFUTT				4. DATE OF DEATH Month Day Year 12 9 1960											
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/8/92		9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Louis Babendrier				14. MOTHER'S MAIDEN NAME Pauline Fisher											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 215-24-4875				17. INFORMANT Springfield Hospital Records Address Sykesville, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia with abscess formation. 493X Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause last. (b) CVA mostly likely due to embolism. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic Reaction, Paranoid type. INTERVAL BETWEEN ONSET AND DEATH weeks															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Sykesville		(County) Carroll		(State) Md.			
21. I certify that (I) (this hospital) attended the deceased from 4-21-60 to 12-9-60 , that (I) (we) last saw the deceased alive on 12-9-60 , and that death occurred at 6 PM from the causes and on the date stated above.															
22a. SIGNATURE Ellis S. Margolin M.D.				22b. DATE 12-9-60				22c. PHYSICIAN'S NAME (Type) Ellis Margolin, M.D.				22d. ADDRESS Sykesville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Sep 13/60				23b. DATE THEREOF 12-9-60				23c. NAME OF CEMETERY OR CREMATORY Landon Park				23d. LOCATION (City, town, or county) (State) Bellevue 29-7 md			
24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Thomas				25a. REC'D BY REGISTRAR Arthur S. Thomas				25b. REGISTRAR'S SIGNATURE Arthur S. Thomas				25c. DATE DEC 12 '60			

13709

CERTIFICATE OF DEATH

13781

Blank certificate form with faint horizontal lines and a circular stamp on the right side.

VS. A15ME
5M 7/59

13710 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEATH
NO.

1

10/10/51

13710

13711

CERTIFICATE OF DEATH

Reg. Dist. No.

13683

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown				c. LENGTH OF STAY IN 1b 16 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taneytown R.D.#2				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Melinda Last Overholtzer				4. DATE OF DEATH Month December Day 14 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 8, 1894	9. AGE (In years lost birthday) 66 yrs.	IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min.	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Franklin Co. Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David A. Keckler				14. MOTHER'S MAIDEN NAME Mary Dentler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mr. Melvin F. Overholtzer, Taneytown, Md.				Address R.D.#2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardio vas. disease DUE TO several years (c) One day							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 1, 1955 to Dec 14, 1960 , that I last saw the deceased alive on Dec 14, 1960 , and that death occurred at 7 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. R. Cadle				ADDRESS (Street, city or town, state) Emmitsburg, Md.			
PHYSICIAN'S NAME (Type) Dr. W. R. Cadle				Emmitsburg, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Dec. 17, 1960			
22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery				22d. LOCATION (City, town, or county) (State) Md. Emmitsburg, Frederick Co.			
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Wilson				ADDRESS Emmitsburg, Md.			
24a. REC'D BY REGISTRAR DEC 19 1960				24b. REGISTRAR'S SIGNATURE Arthur L. Frank			

C. E. Wilson

1

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1878

CERTIFICATE OF DEATH

1878

1

CERTIFICATE OF DEATH

Reg. Dist. No.

13684

13670

1. PLACE OF DEATH o. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. LENGTH OF STAY IN 1b 20 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 172 E. Green St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES A. Middle PAPPAS Last PAPPAS		4. DATE OF DEATH Month DECEMBER Day 15 Year 1960	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1907
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator of lunch room		10b. KIND OF BUSINESS OR INDUSTRY Private Family Home	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Pappas		14. MOTHER'S MAIDEN NAME Patricia L. Harris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ?		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Mrs. J. A. Pappas, Westminister, Md.		Address Same address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY ARTERY DISEASE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 MONTH 8 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 SEPT , 19 60 , to DECEMBER 12 , 19 60 , that I last saw the deceased alive on DECEMBER 12 , 19 60 , and that death occurred at 9:30 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Daniel I. Welliver M.D.		ADDRESS (Street, city or town, state) Ridge Road, Westminister, Md.	
PHYSICIAN'S NAME (Type) DANIEL I. WELLIVER		DATE SIGNED 12-15-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/18/60	22c. NAME OF CEMETERY OR CREMATORY Westminister Cemetery Westminister Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE J. S. Myers, Jr. Westminister Md.		24. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH												
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
13712 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										13685		
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>New Windsor</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-- New Windsor</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>BESSIE</u> Middle <u>RAE</u> Last <u>PURDUM</u>						4. DATE OF DEATH Month <u>December</u> Day <u>2</u> Year <u>1960</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 1, 1888</u>		9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Adam Garver</u>						14. MOTHER'S MAIDEN NAME <u>Sussett Rhinehart</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>				16. SOCIAL SECURITY NO. <u>214-36-1216-A</u>		17. INFORMANT Address <u>Mrs. Willard Horton, Mt. Airy, Md.</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary Insufficiency</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Hours 4r</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u> </u> <u> </u> <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <u>James T. Marsh</u> EXAMINER'S NAME (Type) <u>JAMES T MARSH</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>12/2/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12- 5-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Locust Grove Cemetery</u>			22d. LOCATION (City, town, or country) (State) <u>Frederick Co., Md.</u>					
23. FUNERAL DIRECTOR ADDRESS <u>C. M. Waltz, Winfield, Maryland</u>						24a. REC'D BY REGISTRAR DATE <u>DEC 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				

12088

Official

Winston-Salem, N.C.

FORWARD

April 1, 1955

U.S.A.

Winston-Salem, N.C.

Winston-Salem, N.C.

Winston-Salem, N.C.

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X

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Winston-Salem, N.C.

Winston-Salem, N.C.

Winston-Salem, N.C.

Winston-Salem, N.C.

1 13713 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13686

1. PLACE OF DEATH a. COUNTY Carroll				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 6 mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JULIA Middle SCHLEUNES Last SCHLEUNES				4. DATE OF DEATH Month December Day 1 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 27, 1870	
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Stuttgart Germany			
13. FATHER'S NAME Frederick Gauger				14. MOTHER'S MAIDEN NAME Marie Doderer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Records, Springfield State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 31, 1960 , to December 1, 1960 , that I last saw the deceased alive on December 1, 1960 , and that death occurred at 3:25 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Heinz H. Klaatsch				ADDRESS (Street, city or town, state) Springfield State Hospital			
PHYSICIAN'S NAME (Type) Heinz H. Klaatsch, M. D.				DATE SIGNED 12-1-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/3/60		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tichner				24a. REC'D BY REGISTRAR DATE DEC 2 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1918

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Registrar

Signature of Physician

Signature of Coroner

Signature of Burial Officer

Signature of Minister

Signature of Undertaker

13714 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 CERTIFICATE OF DEATH

Reg. Dist. No.

13687

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middleburg		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brookfield Manor Nursing Home		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First STELLA Middle E. Last SCHOOFF		4. DATE OF DEATH Month Dec. Day 14, Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 Mar. 1879
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 81 Days 14 Hours 19 Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT L. P. Bowlus, Exec. Mt. Airy, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Age DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-10 , 19 60 , to 12-14- , 19 60 that I last saw the deceased alive on 12-11-60 , 19 60 , and that death occurred at 1:30 M from the causes and on the date stated above. ADDRESS (Street, city or town, state) South Main DATE SIGNED 12-14-60 ACTUAL SIGNATURE J. H. Legg M.D. PHYSICIAN'S NAME (Type) T. H. Legg, M.D. Union Bridge, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 19 Dec 1960	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE D. D. Hartley & Sons ADDRESS New Windsor, Md.		24a. REC'D BY REGISTRAR DEC 20 '60 24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

MEDICAL CERTIFICATION

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0725 1551 0

10

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
13715
CERTIFICATE OF DEATH

13688

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highside 3 Dist</u>		c. LENGTH OF STAY IN 1b <u>14 1/2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>Blue Milk Rest Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ada</u> Middle <u>E</u> Last <u>Shipley</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>31</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 15-1873</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>8</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co. Ind.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas J. Miller</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Vernon L. Bonner</u> Address <u>Highville Ind.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Hemorrhage</u> <u>and Arterio Sclerosis + Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>10 yrs.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u></u> Day <u>19</u> Year <u>19</u> Hour a. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 30</u> 19 <u>60</u> to <u>Dec 31</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Dec 30</u> 19 <u>60</u> and that death occurred at <u>7 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Marrell N. Mastin</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>MARRELL N. MASTIN</u>		22d. ADDRESS <u>SPYRESVILLE #2</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/3/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Providence Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Carroll Co. Ind.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u>		ADDRESS <u>Westminster, Md.</u>	
25a. REC'D BY REGISTRAR <u></u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	
DATE <u>JAN 4 '61</u>			

13715

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
13716
13689
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 5 Gorsuch Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle Christian Last Sparwasser, Sr.				4. DATE OF DEATH Month December Day 17 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-11-83	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Clerk				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield State Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremic coma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-renal disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. associated with cerebral arteriosclerosis.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 11-28-1960 to 12-17-1960 , that (I) (we) last saw the deceased alive on 12-17-1960 , and that death occurred at 11:15 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Agustin del Campo 22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12-17-60	
22d. ADDRESS Springfield State Hospital Sykesville, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/21/60		23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE Cem		23d. LOCATION (City, town, or county) (State) Reverend Park Md	
24. FUNERAL DIRECTOR'S SIGNATURE Thomas J. Kenny Inc				ADDRESS 1600 Hollins St		25a. REC'D BY REGISTRAR DEC 21 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus							

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13003

CERTIFICATE OF DEATH

13010



13717

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rum Hampton Rd #1</u>				c. LENGTH OF STAY IN 1b <u>11 wks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hampton Rd #1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Doris - C. Stephen</u>				4. DATE OF DEATH Month Day Year <u>12 27 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/18/15</u>	
9. AGE (In years lost birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sec</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pension Co</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll Co md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Bene F Craft</u>				14. MOTHER'S MAIDEN NAME <u>Susan V. Giggard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>217-09-7160</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno Carcinoma Rectum</u> 154X DUE TO <u>with metastasis to liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>6 Mon</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan</u> , 1948, to <u>12-27</u> , 1960, that I last saw the deceased alive on <u>12-25</u> , 1960, and that death occurred at <u>9 p</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W H Foard</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Manchester, Md 12-29-60</u>			
PHYSICIAN'S NAME (Type) <u>W H Foard M.D.</u>				<u>Manchester, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12/30/60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Manchester</u>				22d. LOCATION (City, town, or county) (State) <u>Manchester, Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fredrick Bush</u>				ADDRESS <u>Hanover Pa</u>			
24a. REC'D BY REGISTRAR <u>Jan 5 '61</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>			

4
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1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/58

04 JAN 1967 - 08 JAN 1967

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

13718

13691

1

STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Carroll</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Woodbine</i>				c. LENGTH OF STAY IN 1b <i>6 mos.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Woodbine</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <i>Woodbine Road</i>			
3. NAME OF DECEASED (Type or print) <i>JOHN</i> First <i>HENRY</i> Middle <i>TESTER</i> Last				4. DATE OF DEATH <i>Dec.</i> Month <i>29</i> Day <i>1960</i> Year			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 2, 1917</i>		9. AGE (In years last birthday) <i>43</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Timber Worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Timber Camp</i>		11. BIRTHPLACE (State or foreign country) <i>N. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Jake Lester</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Ward</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>246-36-2071</i>		17. INFORMANT <i>Mrs. Lucy D. Lester - Woodbine 1, Md.</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <i>420.1</i> IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i> DUE TO <i>Cardiac Arrest</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiac Arrest</i> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>28 Dec 60 to 29 Dec 60</i>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>28 Dec 1960</i> to <i>29 Dec 60</i> , that (I) (we) last saw the deceased alive on <i>29 Dec 1960</i> , and that death occurred at <i>12:30 A. M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>Howard E. Hall</i> M.D.				22b. DATE SIGNED <i>12/29/60</i>			
22c. PHYSICIAN'S NAME (Type) <i>HOWARD E. HALL</i>				22d. ADDRESS <i>SYKESVILLE, MD.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-1-61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oakwood</i>		23d. LOCATION (City, town, or county) (State) <i>Statenville, N. C.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Ruth H. Haight</i> ADDRESS <i>Sykesville, Md.</i>				25a. REC'D BY REGISTRAR <i>4 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanks</i>	

1901

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

1971

CERTIFICATE OF DEATH

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13719

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13692

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN 1b 9 mos.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15 Springfield State Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Lewis Middle N Britton Last WEICH			4. DATE OF DEATH Month 12 Day 25 Year 1960		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-29-94	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) not available			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Delaware			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Albert Welch			14. MOTHER'S MAIDEN NAME Eliza Jane Harrington		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.		
17. INFORMANT Springfield State Hospital, Sykesville, Md.			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 350X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Parkinsonism DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 3-21-1960 to 12-25-1960 , that (I) (we) last saw the deceased alive on 12-25-1960 , and that death occurred at 12 p.m. from the causes and on the date stated above.					
22a. SIGNATURE Agustin del Campo M.D.			22b. DATE SIGNED 12-26-60		
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.			22d. ADDRESS Sykesville, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Dec. 29-1960		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Hollywood	
23d. LOCATION (City, town, or county) Harrington, Delaware		(State)		23e. REC'D BY REGISTRAR DATE JAN 3 '61	
24. FUNERAL DIRECTOR'S SIGNATURE (Mrs) R. H. Boyer, Harrington, Del.			25b. REGISTRAR'S SIGNATURE Arthur S. Hines		

Lewis Britton Welch

1303

CENTRAL OF DEATH

1871

CHIEF OF POLICE

13720
13693
MAYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MAYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MAYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Westminster</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Westminster Md.</i>	
c. LENGTH OF STAY IN 1b <i>5 days</i>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Meadow View Conv. Home</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		f. STREET ADDRESS <i>RFD#5</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>THEODORE WILMER YOUNG</i>		4. DATE OF DEATH Month Day Year <i>Dec. 22 1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 24, 1886</i>
9. AGE (In years lost birthday) yrs. <i>74</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired electrician</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>retail Hardware</i>	
11. BIRTHPLACE (State or foreign country) <i>Carroll Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Young</i>		14. MOTHER'S MAIDEN NAME <i>Anna Frazier</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>215-14-1423</i>	
17. INFORMANT <i>Kelso W. Young</i>		Address <i>Westminster Md. #RDS</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro-vascular accident</i> DUE TO (b) <i>331X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fibrosarcoma left lung</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>4/25 1955</i> to <i>12/22 1960</i> , that (I) (we) last saw the deceased alive on <i>12/22 1960</i> , and that death occurred <i>6:45 P.</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Julius Chapko</i>		22b. DATE SIGNED <i>12/23/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Julius Chapko</i>		22d. ADDRESS <i>85W. Green St WESTMINSTER MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>11/24/60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Taylorville Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Rural Westminster Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. S. Myers, Jr.</i>		25a. REC'D BY REGISTRAR <i>DEC 27 '60</i>	
ADDRESS <i>Westminster, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneen</i>	

13750

Genet

Blackish-brown with 2 large black
spots on the back

THEODORE WILMER YOUNG

Aug. 24 1896

Blackish-brown with 2 large black
spots on the back

Genet

Blackish-brown with 2 large black
spots on the back

Genet

Blackish-brown with 2 large black
spots on the back

Genet

Blackish-brown with 2 large black
spots on the back

Blackish-brown with 2 large black
spots on the back